

## Conducting Filial Therapy With Homeless Parents

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Homelessness and the associated feelings of loss are highly distressing for parents and their children who experience them. The implications for young, homeless children are clinically significant, as these children tend to display higher rates of depressive, anxious feelings. The literature suggests that parents are especially challenged during a period of homelessness, as they cannot provide for their children financially or emotionally. Evidence-based mental health interventions, such as filial therapy, may assist the parent–child relationship by promoting healing during a highly distressing event such as homelessness. Filial therapy, derived from child-centered play therapy, teaches parents to play with their children to express feelings and gain mastery over difficult and often disturbing thoughts and emotions. This article’s purpose is to (a) educate clinicians about the psychological complexities of homelessness with parents and their children and (b) highlight the benefits of using filial therapy as an evidence-based intervention with this population.

*Keywords:* homelessness, filial therapy, parent-child relationship

In 2007, individuals in families comprised more than one third of the total homeless population in the United States; 23% of homeless people were members of families with children (U.S. Conference of Mayors, 2007; U.S. Department of Housing & Urban Development, 2008). These families are typically led by young single mothers and include two or more children, many of whom are younger than 5 years old (Morris & Butt, 2003; National Center on Family Homelessness, 1999). Recently, the rate of single male parents seeking shelter for themselves and their children has statistically increased (Regional Task Force on the Homeless, 2003). A limited supply of and access to low-cost housing in many cities serve as primary causes of homelessness; however, various additional factors contribute to homelessness for families led by single parents. These include, but are not limited to mental health issues and substance abuse (National Coalition for the Homeless, 1999), domestic violence (Anderson, Stuttaford, & Vostanis, 2006; Karim, Tischler, Gregory, & Vostanis, 2006; Swick, 2008), natural disasters (Reganick, 1997), and lack of social support (Philippot, Lecocq, Sempoux, Nachtergaeel, & Galand, 2007; Thrasher & Mowbray, 1995).

Many of the factors that contribute to family homelessness also impair parental functioning, leading to what researchers have labeled a “double crisis” (Hausman & Hammen, 1993). This type of complex crisis occurs when a family endures both the disruptive

experience of losing a stable home and a decline in a parent’s ability to consistently and supportively care for the children. Such a crisis may have short and long-term implications for children of homeless families. At the same time that their basic needs are not being met, children may also lack emotional and psychological care important to success later in life. Thus, many clinicians working with this population need to seek a service model that balances short-term interventions with long-term prevention (Hausman & Hammen, 1993). Primary tasks in supporting caretakers include strengthening their views of self and supporting their roles as parents (Hausman & Hammen, 1993).

Filial therapy is a derivative of child-centered play therapy, where the child experiences unconditional acceptance and positive regard from a mental health therapist. During filial therapy, clinicians work with caretakers to facilitate a positive relationship with their child while learning skills to effectively manage children’s behaviors. Although filial therapy is not aimed toward treating specific behavior problems, its goals include improving self-esteem and the parent–child relationship for both parents and their children (Guo, 2005). Clinicians have used filial therapy successfully with parent–child populations of varying ethnicity, family makeup, and socioeconomic status.

Although there is lack of current research that measures the effectiveness of filial therapy specifically with homeless populations, filial therapy has demonstrated effectiveness with the following populations: racial minorities (Solis, Meyers, & Varjas, 2004), families with high levels of stress (Johnson, Bruhn, Winek, Krepps, & Wiley, 1999; Smith & Landreth, 2003), and single-parent families (Bratton & Landreth, 1995). These demographics primarily characterize homeless populations. A review of research studies examining the usefulness of filial therapy with a variety of target populations (Rennie & Landreth, 2002) revealed that overall, filial therapy resulted in (a) a strengthened parent–child rela-

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tionship, (b) increased parental empathy and children's self-esteem, and (c) decreased parental stress and disordered child behaviors. Parents trained in filial therapy have also reported improved relationships with their spouses, resulting in unification among the family (Bavin-Hoffman, Jennings, & Landreth, 1996). In the case of intact homeless families, this added positive result may be beneficial in maintaining family cohesiveness in a time of high stress and uncertainty.

This article's purpose is to (a) elucidate the experiences of homeless parents as they attempt to meet their families' needs and positively interact with their children, (b) introduce the concept of filial therapy, and (c) propose the use of filial therapy with homeless families. A case study derived from filial work with a past client will further illustrate the applicability of filial therapy with parent-child dyads experiencing homelessness. Implications regarding the appropriateness of this intervention are discussed.

### Effects of Homelessness on Parents, Children, and the Parent-Child Relationship

Homelessness poses many challenges for parents, challenges that can impede the development of healthy parent-child relationships and negatively affect their children's development and functioning. Although the literature on homeless children does not suggest that being homeless is always detrimental to a child's well being, homeless children are placed higher on a continuum of risk than poorly housed children. The continuum of risk includes risks shared by all children (e.g., biological factors), risks shared by low-income children (e.g., exposure to violence), and risks that are specifically related to homelessness (e.g., stressful conditions within a shelter; Buckner, 2008). Although homeless children's placement on the continuum of risk suggests that the experience of being homeless makes them more susceptible to negative life experiences (e.g., poverty, violence), the factors that either mollify or intensify the homeless experience are not well understood at this time.

The literature highlighting factors that protect children from the negative outcomes associated with homelessness is limited. Much of this research has focused on adolescent populations and has suggested that social or family involvement, secure attachments, and positive self-esteem positively affect mental and physical health, and decrease substance use and self-harming behaviors (Kidd & Shahar, 2008; Masten, 2000; Nebbitt, House, Thompson, & Pollio, 2007). Factors that amplify the negative consequences of homelessness have received more attention. These factors include feelings of stigma, shame, instability; loss of homes, friends, and possessions (Buckner, Bassuk, Weinreb, & Brooks, 1999; Walsh & Buckley, 1994); and additional crises such as interpersonal abuse, criminal victimization (e.g., being mugged), or living in abject poverty before or during periods of homelessness (Baggerly, 2003).

These experiences, when coupled with the loss of adequate structure (e.g., eating dinner at the same time, completing homework in the same area or space, evening rituals) and diminished attention and support from parents who must focus on meeting the family's basic needs of food, drink, and shelter, place a child's interpersonal development, academic achievement, and psychological well-being at risk (Nebbit et al., 2007). Past research has shown that rates of developmental delays and mental health issues

in homeless children are higher than those of housed children (Buckner et al., 1999) and that the development of social skills and friendships are lower (Reganick, 1997). Internalizing and externalizing disorders, as well as the disruption of attachments are also of concern for homeless children (Baggerly & Jenkins, 2009).

Although the effects of homelessness can have deleterious psychological effects on children, a strong parent-child relationship provides salient protection from the negative, long-term outcomes that perpetuate a cycle of homelessness. Thus, the importance of fostering positive parent-child interactions within homeless families is germane for children and their families' well-being. Research suggests that even during periods of stress, parents may be able to maintain warmth and support in their parent-child relationships (Newton, 2008; Torquati, 2002).

Swick (2008) highlights the importance of healthy parent-child relationships in homeless situations. Several barriers to successful relationships are discussed, including (a) stereotypic and degrading views by others, (b) isolation from enriching activities, (c) parental lack of knowledge about how to have caring relationships with their children, (d) poor parental self-development, and (e) lack of resources for improving the parent-child relationship.

### *Stereotypic and Degrading Views by Others*

Once a family's resources are depleted, parents experience negative emotional responses, such as shame, fear, anxiety, hopelessness, and powerlessness (Meadows-Oliver, 2003; Morris & Strong, 2004). These experiences are exacerbated when parents feel they are being judged as "lazy" or viewed as an ineffective parent. Stereotyping of homeless individuals has been a longstanding issue that has a considerable impact on those who are struggling daily without housing. In one study, homeless mothers felt strongly that negative stereotypes about homeless women with children were pervasive. They were emphatic in their desire for professionals to recognize the inaccuracy of the stereotypes and images of homeless families (Cosgrove & Flynn, 2005).

### *Isolation From Enriching Activities*

Parent-child dyads are affected by regular interactions and activities in their lives. For parents, a loss of authority frequently occurs in a shelter setting, as other parents and shelter staff may interfere with parents' attempts to discipline their children, or assume the responsibility during activities such as bedtimes, mealtimes, and other aspects of children's daily routines (Boxill & Beaty, 1990; Kissman, 1999). Because of the ambiguity surrounding which authority figure to obey, children may even question their parents' authority by being disrespectful or unwilling to accept limits when they are set (Schultz-Krohn, 2004).

Such experiences add to the chronic adversity and stress that leave homeless parents questioning their own caretaking abilities. With limited social contacts to support their parenting efforts, parents may also feel that their efforts to maintain family routines are diminished (Schultz-Krohn, 2004). These routines serve as attempts to preserve positive family interactions and typical family habits. They range from a regular bedtime to weekly attendance at religious services, and parents may feel that their role of the authority figure in the home is being questioned when these routines are disrupted by shelter staff, other adults, or even chil-

dren. The experience of homelessness, coupled with discord within the shelter, can leave parents feeling exhausted and frustrated as they struggle to maintain structure and positive, stable interactions with their children (Schultz-Krohn).

### *Parental Lack of Knowledge About Ways to Interact With Their Children*

Homeless parents experience pressure to meet their family's basic needs, often leaving little energy to respond to young children's emotional needs (Kelly, Buehlman, & Caldwell, 2000; Kissman, 1999). A lack of childcare and employment opportunities augments frustration and depletion of parenting energy (Morris & Strong, 2004). Often, homeless parents engage in *inconsistent parenting*, when children experience variable attention and unpredictable consequences for negative behaviors or unfulfilled rewards for positive behaviors. (Tischler, Rademeyer, & Vostanis, 2007). The open environment of a homeless shelter may prohibit the parent-child dyad from interacting privately. Parents may struggle to understand what their child needs when they are forced to communicate and express emotions while being observed by other residents and shelter staff (Meadows-Oliver, 2003).

### *Poor Parental Self-Development*

Many homeless parents report feelings of self inadequacy that relate back to childhood or previous adult experiences (Nunez, 1996). When parents feel incapable of making decisions that will positively affect their families, intense feelings of frustration, worthlessness, loss, and desperation often result. Although struggling to strategize a way out of their current situation, they also mourn the loss of their home as well as the loss of privacy, freedom, and pride of ownership (Swick, 2009). Persistent and unavoidable feelings of destitution contribute to high rates of mental health irregularities in parents experiencing homelessness (Tischler, Karim, Gregory, & Vostanis, 2004). These include clinically significant anxious and depressive symptoms (Banyard & Graham-Bermann, 1998; Meadows-Oliver, 2003), as well as negative effects on their experiences of mastery and view of their parenting abilities (Seltser & Miller, 1993).

### *Lack of Resources for Improving the Parent-Child Relationship*

Parents who are preoccupied by the difficulties of homelessness are unlikely to identify emerging psychological issues in their children and less likely to seek help for related behavioral issues (Morris & Butt, 2003). They may (a) lack awareness or knowledge of the severe effects of homelessness on children, (b) be preoccupied with meeting basic family needs, (c) have difficulty obtaining transportation, or (d) attempt to manage immense psychological stress ineffectively, rendering them unable to meet their children's mental needs (Anderson et al., 2006; Kelly et al., 2000).

### *Filial Therapy and Other Parent-Child Therapies*

Recognition of the pivotal role parents play in their children's lives has led to the development of various parent-child therapies. Developed by Bernard and Louise Guerney (Guerney, 2000) in the

1960s, filial therapy was later refined to a time-limited, 10-session model by Garry Landreth (Landreth, 2002). This model was recently manualized (Bratton, Landreth, Kellam, & Blackard, 2006). Filial therapy is an empirically validated process in which mental health professionals train parents to conduct child-centered play sessions with their children (Bratton et al., 2006). Filial therapy has been shown to be an effective and culturally sensitive method of treatment (Chau & Landreth, 1997; Glover & Landreth, 2000; Guo, 2005). Studies demonstrate decreases in internalizing (Tew, Landreth, Joiner, & Solt, 2002), externalizing (Tyndall-Lind, Landreth, & Giordano, 2001), and trauma-related symptoms (Smith & Landreth, 2003) with the use of filial therapy. Further, the effect of play therapy on presenting children's problems are significantly greater when conducted by filial-trained parents as opposed to professionals ( $ES = 1.15$  vs.  $0.72$ , respectively;  $p < .01$ ; Bratton, Ray, Rhine, & Jones, 2005). Although it shares important goals with many parent training models, filial therapy offers a more simplistic and accessible model than some of the others currently available, such as Parent-Child Interaction Therapy (PCIT; Eyberg & Boggs, 1998) or floor time (Greenspan, 1997).

At the time of this writing, filial therapy had been the subject of over 30 studies containing more than 1,000 diverse participants. This body of research, largely based on case studies or empirical studies comparing filial therapy to other play therapy modalities or control groups, consistently found increases in the quality of parent-child relationships, enhancement of parenting skills, and decreases in the child's problem behaviors when filial therapy was the treatment modality utilized (Landreth & Bratton, 2005). There are currently no published studies comparing filial therapy to similar parent-child models such as PCIT or floor time.

PCIT (Eyberg & Boggs, 1998) is an empirically supported behavioral parent-training program that incorporates operant learning and play therapy techniques to treat disruptive behavior problems of children. Although the empirical support and established track record for PCIT is promising, especially in reducing the incidence of child abuse (e.g., Timmer, Urquiza, Zebell, & McGrath, 2005), the model is not yet widely implemented. Some of the barriers to more widespread availability include the high costs for the room setup and audio and visual equipment, as well as the fact that the program is based on live-coaching and a time-intensive training program (Goldfine, Wagner, Bransetter, & McNeil, 2008). Filial therapy has less empirical support than PCIT, but it is an appropriate choice for many populations, given its ability to reach parents and children despite limited time, funding, and training resources (Hunter, 1993; Nadkarni & Leonard, 2007; Smith & Landreth, 2003).

Another method of parent-child therapy similar to filial therapy is popularly known as "floor time" (Greenspan, 1997). This method, while potentially useful with other diagnostic groups, has been primarily utilized to facilitate the symbolic, emotional, and relational development of children on the autism spectrum. During spontaneous "floor time" play sessions, adults follow the child's lead and use affectively toned interactions to facilitate the child's social development. Parents use shared attention, engagement, simple and complex gestures, and problem solving to usher the child into the world of ideas and abstract thinking. The focus of filial therapy, in contrast, is on improving the parent-child relationship, as opposed to aiding the child's cognitive development.

Similar to parents trained in these two similar modalities, parents trained in the filial model are taught skills that emphasize descriptions of behaviors and reflections of feelings. The skills taught in filial therapy are unique in that they are modeled after basic child-centered play therapy skills. These skills include tracking the child's play behavior, focused listening, reflecting feelings, and therapeutic limit setting. These skills are then implemented in structured, weekly play sessions with their children. While in PCIT, the sessions involve the parent, child, and therapist, filial therapy sessions are typically conducted in the home without the therapist. There is less in vivo coaching by the therapist during the sessions. The goal of filial therapy is to support the building of a positive, dynamic parent-child relationship through play (Guerney, 1964). For the child, filial therapy's goals include the development of a safe environment for the expression of feelings, coping skills, confidence, self-esteem, positive behaviors, and the reduction of noncompliant behaviors (VanFleet, 1994). Parents' goals include greater understanding of their child's needs, increased tolerance and acceptance of themselves as parents and their children, and enhanced confidence in parenting ability.

Filial therapists facilitate the process of educating parents and implementing skills in parent-child play sessions. These clinicians (a) generally have a Master's degree or higher in a mental health field (b) have trained specifically in child-centered, nondirective play therapy, and (c) have worked with children and families before learning filial therapy. Filial therapists may also hold the Registered Play Therapist credential issued by the Association for Play Therapy (APT). At this time, training to be a filial therapist is limited to psychologists, social workers, counselors, psychiatrists, family therapists, school counselors, and other experienced professionals who work with children and families. Currently, few graduate programs offer specific training in filial therapy, but guidelines for preparing therapists to facilitate filial therapy emphasize the importance of prior training and supervised experience in play therapy, coursework that clearly explains the filial model, and further supervision in filial therapy once initial training is complete. Landreth and Bratton (2005) stress the necessity for extensive supervision early in training as well as throughout clinical practice.

Filial therapy may be conducted as a standalone treatment or as an additional intervention. Many times, the therapist works individually with a child while simultaneously educating the parents on filial therapy skills. Other times, filial therapy is combined with family therapy. When the second author on this manuscript worked in New Orleans shelters after Hurricane Katrina, filial therapy was completed in conjunction with family therapy sessions to promote healing and support between family members (Green, 2007; Green & House, 2006). Filial therapy has demonstrated effectiveness when both the parent and child have experienced trauma (Smith & Landreth, 2003).

The therapist typically begins filial therapy training with parents by emphasizing the importance of play in understanding a child's world, often describing toys as children's words and play as their language (Landreth, 2002). The therapist also spends time building rapport with the parents. Parents meet with the therapist in sessions without the child present to learn the necessary foundational information and skill set. During these sessions, parents are taught the basic skills of the child-centered, nondirective approach of interaction with their children, such as allowing the child to lead

the play and giving words to the child's nonverbal communication, also known as verbal tracking. An example of verbal tracking might include a therapist or parent saying, "You put that in there," as the child places a block in a bucket. It is important that the parent refrain from naming items, thus allowing the child full creative range in the playroom.

When filial therapy training is conducted in the context of outpatient therapy, several weeks are spent practicing before parents begin to practice these skills in weekly play sessions with their children. Parents are later introduced to more advanced concepts such as returning responsibility, limit-setting, and esteem building (Landreth & Bratton, 2005). The filial model by Landreth and Bratton (2005) takes approximately 10 weeks to complete. This entire process permits therapists to work themselves out of their job with the family so the caretakers can take over the care of the children once they have the skills in place and the child has finished therapeutic work. In the case of a more transient setting, such as a shelter, this training program can be shortened. A study conducted with German mothers attending a health retreat (Grskovic & Goetze, 2008) reported that improvements in parental acceptance, empathy, and positive attention were evident after only 2 weeks of training.

### *Filial Therapy for Homeless Populations*

Homeless parents need access to parenting resources to preserve the parent-child relationship as well as protect their children from the negative effects of homelessness. Filial therapy is an appropriate and beneficial modality for homeless parents and their children in that it addresses several of the parent-child barriers discussed above (Swick, 2008):

1. Filial therapy targets stereotypes that suggest homeless parents are unable or unwilling to work on their parenting skills, as well as parents' feelings of helplessness when they must rely on a professional to resolve problems (Stover & Guerney, 1967).
2. Filial therapy requires regular involvement by both parents and children in an enjoyable, enriching activity together, where their relationship is the priority.
3. Filial therapy educates parents on successful ways to interact with their children, such as acceptance, reflection of feelings, and appropriate limit setting. In studies conducted on parental perception of the model, parents found this knowledge empowering and allowed them to feel better connected to their child (Bavin-Hoffman, Jennings, & Landreth, 1996).
4. Filial therapy addresses parents' feelings of inadequacy or ineffectiveness as parents by affording them the opportunity to be the agent of change in their child's treatment (Landreth, 2002).
5. Filial therapy is accessible to parents and engenders collaboration, cooperation, and support with trainers and other parents. The group format is generally the preferred method because parents provide support for one another (Guerney, 1997). Social support from others is an added



benefit for this population in particular, as lack of social resources is listed as a common problem among homeless parents and a barrier to escaping homelessness (Swick, 2008).

There is flexibility in filial therapy training, which can be conducted in groups in shelters or community centers. Group parenting education opportunities that engage parents and encourage sharing with others similar to themselves are a recommended intervention strategy for this population (Swick, 2009). Such a training environment is enjoyable for parents as well (Foley, Higdon, & White, 2005). This eliminates one challenge of finding transportation to receive services. The only materials needed are toys and a quiet place to conduct the play sessions. Learning the skills requires only an hour per week, and the play sessions between the parent and child last only 30 min per week, although there is also room here for variation.

A daily or weekly group, where a filial therapist conducts training and parents take turns practicing their skills on one another would be one way to implement filial training. A mental health professional may also choose to conduct individual sessions with parents and children if time and space allow. At this time, there is no research available on the outcomes associated with the implementation of filial therapy in a homeless shelter. However, the successful application of filial therapy in a variety of environments (e.g., natural disaster shelters, prisons [Landreth & Lobaugh, 1998]) suggests that it is has promise.

In an effort to disperse filial therapy skills, shelters may also consider allowing staff members to receive filial therapy training. Although filial therapy training has typically been reserved for parents, studies have begun to utilize other trusted or significant adults in children's lives. In one study, fifth grade students conducted filial therapy sessions with kindergarteners as a form of peer mentoring. The older students demonstrated increased empathy and regularly used filial skills after a brief training session [i.e., 4 hours (Robinson, Landreth, & Packman, 2007)]. The training required no funding and served as a catalyst for increased communication between the fifth graders and kindergarteners, as well as between the fifth graders and the teachers. In the same way, shelter staff and parents could use similar training in filial therapy to join together and provide consistency for the children.

Parents may perceive some of the aspects of filial therapy as challenging. However, persistence by the facilitator can have positive results. One case study described a mother who was reticent to participate but found filial therapy training improved confidence in her parenting skills, which resulted in improved self-esteem, self-care, and hopefulness about the future (Garza, Watts, & Kinsworthy, 2007). The therapist can start by reassuring parents of the feasibility of filial therapy in a setting to which they may have access (e.g., shelter, community center). Unlike the extensive room and equipment requirements of PCIT, filial therapy can be conducted in a play area comprised of a blanket and toys in a quiet area. The second author of this article successfully created an area for play and filial therapy in several Red Cross shelters in south Louisiana 2 weeks after the landfall of Hurricane Katrina (Green, 2007; Green & House, 2006). Other researchers discuss implementing play therapy despite limited space and resources (Hunter, 1993; Nadkarni & Leonard, 2007; Smith & Landreth, 2003).

### *Barriers to Filial Therapy for Homeless Parents*

For many homeless parents, learning and implementing effective parenting skills at a time when they feel helpless, overwhelmed, and emotionally unavailable can seem like a daunting task (Bratton & Landreth, 1995). Additional hesitations result from lack of self-esteem, lack of confidence in parenting abilities, or preoccupation with personal issues (Kelly et al., 2000; Morris & Strong, 2004; Swick, 2008). Furthermore, employing filial skills while parenting publicly in a shelter may be difficult for some parents. Concerns about whether or not they are viewed as a competent parent may also be a concern, especially when they are practicing maintaining a permissive and nondirective stance (Solis et al., 2004). Therapists can help to reduce these concerns by educating staff on the model. Staff members may even be encouraged to allow parents to practice their skills and children to experience limit setting by their parents only, as opposed to numerous adults throughout the shelter.

### *Benefits for Homeless Children*

Parents may be encouraged by the support child-centered play modalities receive from the research literature on homeless children. Individual play therapy has demonstrated effectiveness in improving behavior and self-esteem and decreasing anxiety in children living in temporary residences (Baggerly, 2004; Kot, Landreth, & Giordano, 1995; Tyndall-Lind et al., 2001). Homeless children in play therapy can experience a quiet time away from the harsh reality of life without a home. Through the unconditional acceptance of the therapeutic relationship, children's needs for physical and psychological safety are met as the therapist sets appropriate limits and instills the notion that all people are worthy, regardless of their socioeconomic status (Baggerly, 2003; Landreth, 2002; Walsh & Buckley, 1994). Permission to direct the play provides the child with the power and control he or she lacks as a member of a homeless family. Further, it allays the adverse impact of homelessness by providing an environment where the child can resolve difficult emotional experiences and develop the skill base to cope with future challenges.

### *Benefits of Parental Involvement*

Such gains from child-directed play therapy can be intensified when the child and parent are afforded the opportunity to experience the power of play together and strengthen any disrupted attachments that have occurred between them (Landreth & Bratton, 2005). Parents and children are able to have a regular, enjoyable, one-on-one experience together (Cleveland & Landreth, 1997), and research has indicated the significance of parental involvement in the success of play therapy (Bratton et al., 2005; Ray, Bratton, Rhine, & Jones, 2001). Bratton and her colleagues' meta-analyses concluded that play therapy conducted by parents produced a very large effect size ( $d = 1.05$ ), as compared with play therapy by a mental health professional that yielded a moderate-to-large effect size ( $d = 0.72$ ). These findings suggest the inclusion of parents in the play therapy process results in positive treatment outcomes and the development of skills, which can play a preventative and/or reparative role for both the child and the family system. Once parents are able to experience the bene-

fits, encouraging them to experience more activities with their children at school or in the community can serve to further strengthen the parent-child relationship (Knitzer & Lefkowitz, 2006).

### Case Study

Sarita is a 30 year old, Hispanic female living in a homeless shelter in the southern portion of the United States. She has one child, a 5-year-old male, named Miguel. Sarita is currently unemployed and has been living in the shelter for 2 weeks. She recently left her spouse because of physical and emotional abuse. Sarita has a trauma history, including childhood sexual abuse while she was living in a foster home during her preteen years. Sarita began using cocaine shortly after running away from her foster home. She lived in several homeless shelters until she met her husband, whom she was married to for 6 years. Sarita attended Narcotics Anonymous meetings regularly and had been drug free for several years. One year after giving birth to Miguel, Sarita reports that she relapsed because of the stress of the infant and from the domestic violence by her husband. She and Miguel left her husband after he pushed her down a flight of stairs, and she broke her arm. Miguel witnessed much of this violence. Sarita is in recovery from substance abuse and reports that she has been drug-free for 6 months. She reports depressive symptoms related to her homelessness and failed marriage, but says she is hopeful.

Others in the shelter have witnessed Sarita's struggle to discipline her son. At times, he can be aggressive toward her, which she responds to by withdrawing from him, and relocating to an alternate room while he is left alone. Miguel began demonstrating attention-seeking behaviors such as behavioral tantrums during mealtimes, physical aggression toward other children, and disobedience with authority figures. Miguel's disordered behaviors decreased the emotional closeness between him and his mother.

Filial therapy was recommended in an attempt to decrease Miguel's problem behaviors and improve the parent-child relationship. Simultaneously, Sarita attended individual psychotherapy to address her traumatic stress and assist her in remaining drug-free.

The play therapist arranged to meet Sarita at the shelter, where Sarita learned about filial therapy and practiced her skills with the play therapist role-playing a child. She and the therapist arranged a blanket and toys in a corner of the shelter's main room to act as their play area, and the therapist modeled facilitative statements and reinforcement through her interactions with Sarita. Sessions began with the therapist educating Sarita about play therapy, emphasizing the importance of focusing on the relationship and not the problem. Sarita was taught reflective responding, which is comprised of following the child rather than leading, and reflecting behaviors, thoughts, and feelings without asking questions (Bratton et al., 2006). She was also taught the A-C-T model of limit setting, where (a) "A" represents acknowledging the feeling, (b) "C" represents communication of the limit, and (c) "T" represents targeting an alternative. If Miguel attempted to hit Sarita out of anger, for example, she would use this model to set a limit by saying, "Miguel, I know you're angry at me (A), but I'm not for hitting (C). You can hit that stuffed animal (T)."

After 2 weeks of psychoeducation and practicing skills, Miguel became involved in the sessions. Sarita reported feeling nervous

about using her new skills and concerned that Miguel would respond negatively to her new style of parenting. To ease her anxiety during this first session and continue modeling the skills, the therapist acted as a cotherapist and participated in the session with Sarita and Miguel. Miguel was intrigued by the play area and immediately began manipulating the army figures. To Sarita's surprise, Miguel engaged both her and the therapist in his play. He told Sarita where to place the army men and conversed with her about them, saying, "You put that guy there. They're going to fight now." Although Sarita had expressed concern over Miguel staying in the play area, Miguel was engrossed in the new experience and made no effort to leave. In fact, he appeared disappointed when Sarita gave him a 5-min warning of the end of the session. The therapist modeled being "a thermostat, not a thermometer" (Bratton & Landreth, 2006) by saying, "Miguel, you're sad that your special play time is over with your mom for today."

After the session concluded, Sarita and the therapist discussed the experience of participating in a filial session. Although Sarita reported feeling comfortable tracking Miguel's play, she said she did not feel confident making reflective statements. She also discussed her feelings of frustration when Miguel did not want to leave the play area. Overall, Sarita reported having a positive first experience with filial therapy.

Over the next 2 weeks, the therapist continued visiting Sarita and Miguel. While she observed the next filial session, she did not colead, and Sarita was given the opportunity to have rare one-on-one time with Miguel, which Miguel responded to with enthusiasm, as evidenced in the following dialogue:

Miguel: Oh! A ball!

Sarita: You found something you want to play with.

Miguel: Yup. I'll hit it to you and then you hit it back to me.

Sarita: Okay.

Miguel (getting excited): You got it! Now hit it back to me!

Sarita (smiling): You're having fun!

Sarita practiced her newly learned skills, increasing her verbal tracking with comments such as, "You're working really hard on that," and responding skills by allowing Miguel to lead and accurately reflecting his thoughts and feelings. Sarita reported after her second filial session with Miguel that she was surprised that Miguel was happy to spend time with her. She expected Miguel to be angry with her or ashamed of her because she had allowed her husband to abuse her and because of their current living environment. However, Miguel conveyed he was happy to spend special, uninterrupted time with his mother.

After observing three additional filial therapy sessions, the therapist began conducting weekly check-ins with Sarita via telephone. Sarita reported that the filial sessions were producing positive outcomes, and Miguel frequently asked her throughout the week when they would have "special play time" together. She did report some difficulties with attempting filial therapy in a shelter environment, such as lack of space. Meetings and events in the main room sometimes made it difficult for Sarita to conduct special playtime with her when she wished. Additionally, she reported that other children sometimes asked her to play with them or wanted to join in her sessions with Miguel. She sounded proud of herself when she told the therapist that she had set a limit on this, telling

the other children, "I know you really want to play with us, but right now is our special play time. You can play with Miguel and me when our special play time is over." She also reported telling some of her fellow residents about filial therapy.

Filial therapy had a positive effect on the parent-child relationship, Sarita's confidence, and Miguel's behaviors. Specifically, once he felt confident that he would have Sarita's attention, Miguel's disordered behaviors appeared to decrease. He responded well to Sarita's limit setting, especially around mealtimes when he previously had tantrums. His mother reported that his aggression decreased and his affection toward his mother and peers increased. Because his behaviors improved, he made friends more easily and was able to maintain the friendships through the sharing and turn-taking skills he had learned through filial therapy. Filial therapy, coupled with individual therapy, enabled Sarita to build self-confidence and feel more capable of parenting Miguel effectively. She no longer left him alone when he acted out; rather, the therapist encouraged her to begin using some of her filial skills, such as limit-setting and empathy when Miguel became upset. Experiencing success in one area of her life gave Sarita the confidence and determination necessary to escaping homelessness. Most importantly, having positive social interactions in their filial sessions gave Sarita and Miguel temporary relief from the stress of their homelessness.

### Implications for Practitioners

Interventions for homeless families are more likely to be successful if they consider families' barriers to mental health care. A successful intervention for homeless families would include treatment that is flexible, transportable, rewarding for parents, applicable for a range of socioeconomic and racial groups, practical for conducting in a shelter environment, and engaging for its participants. The research on premature termination in child psychotherapy indicates that young, single, minority parents from a low socioeconomic status with minimal outside social support are the least likely to continue treatment (Topham & Wampler, 2008). As stated previously, parents with these characteristics are commonly observed in the homeless population (Morris & Butt, 2003; Gervais & Rehman, 2005; National Center on Family Homelessness, 1999; Philippot et al., 2007; Thrasher & Mowbray, 1995), suggesting that clinicians focus on engagement as a primary goal of treatment and that work toward this goal be evident at various stages of treatment. Other goals might include the facilitation of child development, improvement of the parent-child relationship, identification of children's needs, and explanation of coping mechanisms for handling problem behaviors and decreasing parents' stress levels.

Allowing time for parents and children to play together decreases parents' experiences of stress related to raising a family (Foley et al., 2006). Decreases in parental stress leads to more effective parenting, which correlates with (a) decreases in young children's problem behaviors (Egeland, Kaloske, Gottesman, & Erickson, 1990), (b) mitigation of violence incumbent in high-risk environments (Miliotis, Sesma, Masten, 1999), and (c) increases in academic and social success (Miliotis et al., 1999). Further, the security, nurturance, and communication provided by healthy attachment within a parent-child relationship allows the child to take risks and experience success (Kelly et al., 2000; Miliotis et al.,

1999). It should be noted that while filial therapy is not intended as a treatment for parents' mental health issues, parents have reported increased confidence and self-awareness as a result of filial training (Foley et al., 2005). Homeless parents who are suffering with depression, anxiety, posttraumatic responses are encouraged to seek individual counseling to regain their abilities to be effective parents for their children (Steinbock, 1995). Filial therapy is also not an appropriate standalone treatment for children's issues such as trauma, depression, or disruptive behaviors. Filial therapists can aid families by sharing knowledge about available resources in the community and advocating for both parents and children in cases where it may be difficult to find affordable services. Additionally, filial therapy is not meant as a solution to the family's homeless situation, although clinicians can utilize filial therapy as a way to build parents' confidence in handling stressful situations (Foley et al., 2006). It is important that filial therapists be equipped with knowledge of local resources that can assist families in meeting their basic daily needs.

### Conclusion

Homelessness can produce adverse effects on children's development. When items low on a family's hierarchy of needs (i.e., food, shelter, safety) are unmet and the future is uncertain, parenting abilities are often negatively affected. Research has focused much of its attention on the effects that parenting can have in a homeless situation and suggest that it plays a critical role in the spectrum of child development.

Filial therapy is one way for parents to improve interactions with their children, even under extreme stress during a crisis situation such as homelessness. Empirically supported and widely used, incorporating parents in filial therapy as a means of therapeutic work with homeless children is one way to extend long-term treatment to those without easy access to services, regardless of the length of their stay in a particular shelter or where they may move in the future (Smith & Landreth, 2003). Filial therapy serves as a preventative and therapeutic function, as the skills parents learn and implement can improve parent-child relationships. This relationship acts as a cornerstone for children's self-esteem and mental health (Green & Kolos, in press). Filial therapy offers empowerment to the parent and safety and structure to the child during a time when they feel most disempowered.

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